BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
	)	
CATHERINE ELIZABETH MOIZEAU, M.D.	)	Case No. 800-2016-021005
Physician's and Surgeon's	)	
Certificate No. A81624	)	OAH No. 2017120199
	)	
Respondent	)	
	)	
	)	

ORDER DENYING PETITION FOR RECONSIDERATION

The Petition filed by M. Bradley Wishek, Esq., attorney for Catherine Elizabeth Moizeau, M.D., for the reconsideration of the decision in the above-entitled matter having been read and considered by the Medical Board of California, is hereby denied.

This Decision remains effective at 5:00 p.m. on **August 6, 2018**.

IT IS SO ORDERED: August 6, 2018.

Kristina Lawson, JD, Chair
Panel B

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
	)	MBC No. 800-2016-021005
CATHERINE ELIZABETH MOIZEAU, M.D.	)	
	)	OAH No. 2017120199
Physician's and Surgeon's	)	
Certificate No. A81624	)	**ORDER GRANTING STAY**
	)	
	)	(Government Code Section 11521)
Respondent	)	

M. Bradley Wishek, Esq., on behalf of respondent, Catherine Elizabeth Moizeau, M.D., has filed a Petition for Reconsideration/Order to Redact Confidential Information of the Decision in this matter with an effective date of July 27, 2018, at 5:00 p.m..

Execution is stayed until **August 6, 2018**.

This stay is granted solely for the purpose of allowing the Board time to review and consider the Petition for Reconsideration/Order to Redact Confidential Information.

DATED: July 23, 2018

Kimberly Kirchmeyer
Executive Director
Medical Board of California

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
CATHERINE ELIZABETH MOIZEAU, M.D.	)	**Case No. 800-2016-021005**
Physician's and Surgeon's Certificate No. A81624	)	**OAH No. 2017120199**
Respondent	)	

DECISION

The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on July 27, 2018.

IT IS SO ORDERED: June 27, 2018.

MEDICAL BOARD OF CALIFORNIA

Kristina Lawson, JD, Chair
Panel B

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: CATHERINE ELIZABETH MOIZEAU, M.D., Physician's and Surgeon's Certificate No. A81624 Respondent.	Case No. 800-2016-021005 OAH No. 2017120199

PROPOSED DECISION

Administrative Law Judge Juliet E. Cox, State of California, Office of Administrative Hearings, heard this matter on April 24 and 26, 2018, in Oakland, California.

Deputy Attorney General Greg W. Chambers represented complainant Kimberly Kirchmeyer, Executive Director of the Medical Board of California.

Attorney M. Bradley Wishek represented respondent Catherine Elizabeth Moizeau, M.D., who was present for the hearing.

The matter was submitted for decision on April 26, 2018.

FACTUAL FINDINGS

1. Respondent Catherine Elizabeth Moizeau, M.D., has practiced medicine in California for about 15 years. The Medical Board of California (Board) issued Physician's and Surgeon's Certificate No. A81624 to her effective January 8, 2003. At the time of the hearing, this certificate was active, and was scheduled to expire on November 30, 2018.

2. On June 22, 2017, acting in her official capacity as Executive Director of the Board, complainant Kimberly Kirchmeyer filed an accusation alleging that respondent's mental illness impairs her ability to practice medicine safely. Complainant seeks an order imposing probationary restrictions on respondent.

Educational History and Professional Experience

3. Respondent graduated from California State University, Northridge. She began medical school in 1996 at Saint Louis University School of Medicine, and graduated in 2000. She did a two-year obstetrics and gynecology residency in New Jersey, followed by an additional year as a community and family medicine resident at the University of California, Davis, Medical Center.

4. Respondent is not board-certified in any medical specialty. She has practiced in primary and urgent care. Since 2008, respondent's medical practice has emphasized chronic liver disease, and particularly treatment of hepatitis C among low-income patients. She has published educational articles and advocated to the California legislature regarding best clinical and public health practices for treating hepatitis C.

5. Respondent currently splits her professional time between two primary care clinics, one in Placerville and one in Sacramento. At each, she treats many patients with liver disease. Between December 2010 and January 2016, respondent also spent three days each week working in a primary care clinic at Adventist Family Health Care in Clearlake.

6. Respondent has never been disciplined by the Board, or sued for malpractice.

Current Mental Health Diagnosis and Treatment

7. Since April 2017, two forensic psychiatrists (Gloria Kardong, M.D., and Jessica Ferranti, M.D.) have examined respondent and reviewed medical records about her dating back to 1999.[1] Dr. Kardong examined respondent in April 2017, to determine for the Medical Board whether respondent suffered a mental illness impairing her ability to practice medicine safely. Dr. Ferranti examined respondent in February 2018, upon referral by respondent's treating psychiatrist, Peter Yellowlees, M.D.

8. Both Dr. Kardong and Dr. Ferranti diagnosed respondent with bipolar I disorder. Dr. Yellowlees concurs in this diagnosis, and has prescribed medication and other treatment for respondent.

9. Respondent herself also concurs in these psychiatrists' diagnosis. She has accepted Dr. Yellowlees's treatment recommendation and intends to continue seeing him for treatment and following his medical advice.

10. Bipolar I disorder causes severe mood fluctuations. Its key diagnostic criterion is a "manic episode," in which the patient is hyperactive and abnormally energetic. In mania, patients experience racing, grandiose thoughts, and sometimes paranoia or

[1] A third forensic psychiatrist (Robert Dolgoff, M.D.), examined respondent in late 2016. His diagnostic opinion was not in evidence.

delusion. Their judgment is strongly impaired, and they often engage in unpredictable or risky behavior.

11. Some people with bipolar I disorder have only one manic episode in their lives, but patients more commonly have multiple manic episodes. Between manic episodes, patients usually experience periods of apparently normal cognitive and emotional function and periods of depression that can be mild or severe.

12. Although patients and people close to them sometimes can identify incipient mania through subtle symptoms or behaviors ("prodromal" signs), no technique reliably can predict mania before its prodromal signs emerge. Psychotropic medications can end an episode of mania, but without medical treatment manic episodes often last for weeks or even months before resolving.

13. Mood-stabilizing medication is the only intervention that is effective to prevent manic episodes among people with bipolar I disorder. Lamotrigine is one effective medication, but it causes a serious, potentially life-threatening skin disorder in a small minority of patients. To minimize the risk of this side effect, a patient must begin taking lamotrigine in a small dose, gradually increasing the dose over six to eight weeks to a stable therapeutic level.

14. Following Dr. Yellowlees's prescription, respondent began taking lamotrigine in late March 2018. She also has taken several other steps that both Dr. Yellowlees and Dr. Kardong endorse to improve her mental health and to enlist her friends, family, and professional colleagues in helping her manage her disease.

Mental Health Treatment History

15. Since she was a young adult, respondent has received intermittent but not consistent treatment for mental health problems. All of the psychiatrists who recently have diagnosed respondent with bipolar I disorder consider the mental health treatment history they reviewed to support this diagnosis.

INVOLUNTARY PSYCHIATRIC HOSPITALIZATIONS

16. In 1999 and again in 2016, respondent was hospitalized involuntarily for psychiatric treatment. Psychiatrists who treated respondent during each of these hospitalizations suggested to her that she had bipolar I disorder, but respondent rejected this diagnosis. Dr. Yellowlees, Dr. Kardong, and Dr. Ferranti agreed, however, that respondent's 1999 and 2016 hospitalizations arose from manic episodes characteristic of bipolar I disorder.

17. The 1999 hospitalization occurred at the end of respondent's third year of medical school, after a period of increasingly erratic, hostile, and delusional behavior accompanied by about five days without sleep.

18. Respondent spent two weeks in the hospital in 1999, and records from this hospital stay were in evidence. A hospital psychiatrist's initial assessment was, "Psychotic disorder, not otherwise specified. Rule out bipolar disorder with psychosis, manic. Rule out major depressive disorder with psychosis. Rule out schizophrenia. Rule out organic syndrome."

19. On January 25, 2016, respondent abruptly left an appointment with a patient at the Adventist Family Health Care clinic who had sought urgent care because of signs suggesting an impending miscarriage. Respondent did not examine the patient and did not arrange for any other qualified clinician to do so.

20. On January 26, 2016, Adventist Family Health Care clinic staff members became so concerned about respondent's agitated, hostile behavior that they called City of Clearlake police officers. The officers escorted respondent from her workplace to the emergency room at Saint Helena Hospital, Clearlake, where they requested a psychiatric evaluation for her under Welfare and Institutions Code section 5150.[2]

21. Respondent spent about five days in the hospital, but records from this hospital treatment were not in evidence. Respondent testified that she did not recall what diagnosis, if any, her treating psychiatrists had given her during her 2016 hospitalization. Her psychotherapist's records reflect their discussions regarding a diagnosis of bipolar I disorder, however.

VOLUNTARY TREATMENT

22. Respondent sought mental health treatment before 1999. She had received psychotherapy or other counseling during adolescence and young adulthood, although no evidence described in any detail when she had done so or for what reasons. In the early 1980's, when she was in college, respondent was hospitalized briefly; she testified that this hospital treatment was for depression.

23. The evidence did not establish that respondent consulted a psychotherapist or psychiatrist at any time between her hospital discharge in August 1999 and her admission in January 2016. Records from respondent's primary care physician (Olivier Seban, M.D.) state that he recommended to respondent on several occasions between 2005 and 2015 that she consult a psychiatrist, but that to his knowledge she did not.

24. The evidence did not establish what treatment recommendations respondent received upon her discharge from the hospital in early 2016. Respondent began seeing Carol Kirshnit, Ph.D. for psychotherapy in February 2016, about two weeks after her discharge. Respondent selected Dr. Kirshnit because she believed that she "needed to regroup" after her

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[2] The Adventist Family Health Care clinic's medical director reported this incident to the Board, causing the investigation that preceded the accusation in this matter.

hospitalization, and because Dr. Kirshnit has extensive experience providing mental health care to physicians.

25. After a few months of psychotherapy, including discussions of respondent's 2016 hospitalization, Dr. Kirshnit recommended that respondent consult a psychiatrist. Respondent resisted this advice for several more months. In February 2017, however, respondent first consulted Dr. Yellowlees.

26. Dr. Yellowlees's notes state that at their first few meetings in February and March 2017, respondent denied to him that she ever had experienced any psychiatric disturbance resembling mania or psychosis.[3] She told him that she had been psychiatrically hospitalized in 1999 and in 2016, but she did not provide him initially with records from either hospitalization. Dr. Yellowlees did not realize until he read those records in early 2018 that respondent's treatment providers on each occasion had reported observing both mania and delusions.

27. Dr. Yellowlees referred respondent to Dr. Ferranti after reviewing Dr. Kardong's written report, and after discussing Dr. Kardong's opinion with respondent. Dr. Ferranti prepared a report concurring in Dr. Kardong's diagnosis, and discussed her opinions with Dr. Yellowlees. Only after receiving this further forensic opinion in March 2018 did Dr. Yellowlees adopt Dr. Kardong's and Dr. Ferranti's diagnosis and prescribe lamotrigine for respondent.

Prognosis

28. In her own clinical practice, Dr. Kardong treats physicians, including physicians with bipolar I disorder. Her opinion is that untreated bipolar I disorder impairs a physician's ability to practice medicine safely, because manic episodes render the patient incapable of controlling his or her thoughts, emotions, or actions. For example, Dr. Kardong believes that respondent was unable to practice medicine safely on January 26, 2016.

29. By blunting or eliminating manic episodes, appropriate and effective treatment permits many of Dr. Kardong's physician patients with bipolar I disorder to practice medicine safely and successfully.

30. Dr. Yellowlees also treats physicians in addition to respondent. Like Dr. Kardong, Dr. Yellowlees believes based on his own patients' experience that physicians with bipolar I disorder who receive appropriate, effective treatment can practice medicine safely.

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[3] Similarly, Dr. Kardong testified credibly that when she interviewed respondent in April 2017, respondent described anxiety, stress, and miscommunication as having led to her hospitalizations; contemporaneous written records, in contrast, described significant agitation and delusion.

31. Dr. Kardong believes that respondent can practice medicine safely "when not having an episode like the ones she has experienced." (By "episode," Dr. Kardong referred to a manic episode, such as those that caused respondent's hospitalizations.) Dr. Kardong's further opinion is that to reduce the probability of future manic episodes to a level that Dr. Kardong would consider reasonably safe, respondent must adhere to treatment with mood-stabilizing medication such as lamotrigine.

32. Dr. Yellowlees agreed with Dr. Kardong that respondent should continue treatment with mood-stabilizing medication for the foreseeable future.

33. Although Dr. Ferranti did not testify, her report was in evidence and Dr. Yellowlees testified that he endorses Dr. Ferranti's opinions and conclusions. Dr. Ferranti's report states her opinion that "to be reliably and consistently fit for duty and to ensure public safety, [respondent] needs to be on a regimen of mood stabilizing medication." In other words, respondent "is fit to practice medicine as long as she is adherent to evidence-based treatment and management for bipolar I disorder."

34. In March 2017, respondent underwent an assessment of her fitness to practice medicine, through the Physician Assessment and Clinical Education (PACE) program at the University of California, San Diego. A short summary report from this evaluation was in evidence, recommending that respondent "continue treatment with her psychologist and psychiatrist for monitoring of her mood symptoms."

35. Dr. Kardong believes that respondent should abstain entirely from consuming alcohol. Her opinion on this issue did not rest on any observations specific to respondent; for example, Dr. Kardong did not state that she believes respondent ever to have abused alcohol. Rather, Dr. Kardong bases her view that respondent should abstain from alcohol on the general observation that alcohol itself is a mood-destabilizing drug.[4]

36. Dr. Yellowlees acknowledged that substance abuse, including alcohol abuse, is more common among patients with untreated or poorly managed bipolar I disorder than among the general population. His opinion, however, is that unless a patient with bipolar I disorder also has an alcohol use disorder, no clinical reason exists for the patient to abstain scrupulously from alcohol. Because respondent has not demonstrated, to his knowledge, any difficulty managing her alcohol consumption, he has not counseled her to give up alcohol entirely as part of her treatment for bipolar I disorder.

Analysis

37. The opinions summarized in Findings 8 and 28 through 34 are consistent, and persuasive.

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[4] Dr. Kardong also would advise respondent to abstain from caffeine. She did not address any other non-prescription mood-altering substances, such as nicotine or cannabis.

38. Respondent has bipolar I disorder. This chronic disease has caused her to experience manic episodes during which she could not practice medicine safely. Because of the risk that she will suffer another disabling manic episode, bipolar I disorder impairs respondent's ability to practice medicine safely.

39. With clinically appropriate treatment for her bipolar I disorder, the probability that respondent will experience another disabling manic episode is low enough to permit her to practice medicine safely.

40. The evidence did not establish that respondent has an alcohol use disorder, or that she ever has experienced difficulty limiting her alcohol consumption. For this reason, Dr. Kardong's opinion regarding the role of alcohol abstinence in respondent's treatment is less persuasive than Dr. Yellowlees's opinion. The available evidence does not establish that proper treatment of respondent's disease requires her to abstain entirely from consuming alcohol.

41. Over nearly 20 years before March 2018, respondent missed opportunities to receive a correct diagnosis and appropriate treatment.

a. As summarized in Findings 16 through 21, physicians who treated respondent during her involuntary hospitalizations in 1999 and in 2016 diagnosed bipolar I disorder, at least tentatively. Once released from involuntary treatment, however, respondent not only did not pursue voluntary psychiatric care but in fact (as summarized in Findings 23 through 25) resisted other providers' efforts to direct her to it.

b. As summarized in Finding 26, when respondent did seek mental health care on her own volition she misinformed her treatment providers regarding her symptoms and history.[5]

c. When respondent received Dr. Kardong's forensic diagnosis, she further delayed accepting it, as summarized in Findings 26 and 27. Instead, she preferred to rely on advice from Dr. Yellowlees, to whom she had not provided all pertinent information.

42. At the time of the hearing, respondent was receiving clinically appropriate treatment for bipolar I disorder. She had been receiving such treatment for about a month.

Community Support

43. Wayne J. Daniel, D.O., is the medical director of the clinic where respondent works in Placerville. Respondent has told Dr. Daniel that she has been involuntarily hospitalized twice in her life, both times for mania with psychosis, and that she has bipolar I disorder. They also have discussed prodromal signs of mania. Dr. Daniel works closely and

[5] Dr. Yellowlees testified credibly that people who experience manic episodes often do not recall completely or accurately what occurred, or why, during an episode.

regularly with respondent, and has assured her that he would intervene to stop her from practicing and to encourage her to consult her psychiatrist if he saw any such signs in respondent. Dr. Daniels provided a declaration stating that during the approximately five years they have worked together, however, he has never observed respondent to be anything other than a competent and effective physician.

44. Respondent also has discussed her hospitalizations, her diagnosis, and prodromal signs of mania with Ian R. Johnson, M.D., medical director of the clinic where respondent works in Sacramento, and with Chainaronk Limanon, M.D., a colleague at that clinic with whom respondent works regularly. Both Dr. Johnson and Dr. Limanon have assured respondent that they would intervene to stop her from practicing and to encourage her to consult her psychiatrist if they saw any signs of mental distress in her. According to written statements they provided, neither Dr. Johnson nor Dr. Limanon has observed any impairment in respondent; both have confidence in her medical skills.

45. Throughout her career, respondent has supervised nurse practitioners and physician assistants. At the Placerville clinic, respondent supervises two physician assistants and one family nurse practitioner. No one ever has raised any concerns about her ability to supervise these clinicians effectively, and her ability to do so is essential to the clinic's services.

46. Christian J. Miller is respondent's fiancé. He confirmed that respondent takes Dr. Kirshnit's and Dr. Yellowlees's advice seriously and that she is conscientious about following it. He has educated himself regarding prodromal signs of mania and believes he would be able to recognize those signs if they occurred in respondent,[6] and intervene with her or her psychiatrist. Miller and Dr. Yellowlees both testified credibly that they intend to schedule a meeting soon in which Dr. Yellowlees can counsel Miller further on how to support respondent.

47. Samantha J. Flynn has been respondent's close friend for about 30 years. Flynn has worked as a psychiatric technician, and knew from her regular telephone communication with respondent in the weeks before respondent's January 2016 hospitalization that something was wrong with respondent. In hindsight, and with further education regarding signs and symptoms of bipolar I disorder, Flynn recognizes respondent's behavior during that period as having been characteristic of emerging mania. Like Miller, Flynn now knows that if she sees similar signs again, she should advise respondent and if necessary should inform Miller or Dr. Yellowlees.

48. Respondent presented three other reference letters, all from persons able to comment on her medical skills. Lorenzo Rossaro, M.D., has known respondent since 2009 because of her practice focus on hepatitis C; he views her as a careful and diligent clinician. Kasey Lonbaken, R.N., has worked with respondent at the Placerville clinic since 2010, and

[6] Miller did not see or speak to respondent regularly during the weeks before her January 2016 hospitalization.

has observed only skillful, dependable, and compassionate care. Finally, Jerry Bliatout, J.D., is the chief executive of the organization that operates the Sacramento clinic where respondent works. He notes that respondent has good working relationships with all of her colleagues and is very valuable to some of the clinic's most difficult patients.

LEGAL CONCLUSIONS

1. The Board may discipline respondent's physician's and surgeon's certificate only upon presenting clear and convincing proof, to a reasonable certainty, of the facts establishing cause for discipline. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) The factual findings above reflect this standard.

2. The Board may take disciplinary action against respondent if her "ability to practice [medicine] safely is impaired because [she] is mentally ill." (Bus. & Prof. Code, § 822.) The matters stated in Finding 38 establish that respondent's mental illness, bipolar I disorder, impairs her ability to practice medicine safely. Cause exists for discipline against respondent under Business and Professions Code section 822.

3. The matters stated in Finding 39 confirm that proper treatment—which may or may not continue—can mitigate impairment that respondent otherwise would experience because of her chronic illness. These matters are appropriate considerations for the Board in exercising its discretion regarding whether to impose any of the disciplinary actions that Business and Professions Code section 822 permits, or if so which one. They are not matters refuting cause for discipline against respondent.

4. Although the matters stated in Findings 16 through 20, 23 through 27, 43, 44, and 48 showed that respondent has had long periods between debilitating manic episodes, they do not show that she has a long experience of effective treatment. The matters stated in Findings 13, 14, and 42 establish that respondent currently is receiving treatment that is likely to be effective. At the same time, these matters establish that respondent has not been using mood-stabilizing medication long enough to confirm that this medication is safe and effective for her and that she can continue using it for the foreseeable future.

5. The matters stated in Findings 9, 14, 42, 43, 44, 46, and 47 demonstrate that respondent recently has taken responsibility for managing her illness, and has enlisted a strong team of professionals, close friends, and colleagues to assist her. The matters stated in Findings 9, 14 through 21, 23 through 27, and 42, however, demonstrate that this treatment program had been in full effect for only about a month before the hearing in this matter, even though opportunities to implement such a program had been available to respondent for almost 20 years. Respondent's history of resisting diagnosis and treatment for her illness raises concern that she may waver in the future in her commitment to following her treating psychiatrist's and psychotherapist's recommendations.

6. One of the options available to the Board is to place respondent on probation. (Bus. & Prof. Code, §§ 822, subd. (c), 2227, subd. (a)(3).) Under the circumstances in this matter, probation is appropriate, to permit the Board to ensure that respondent adheres to a treatment program that is effective for her.

7. Complainant advocated at the hearing for inclusion among respondent's probation conditions of conditions requiring her to abstain from alcohol, and to undergo biological fluid testing to confirm abstinence. The matters stated in Finding 40 do not establish that these optional conditions are appropriate for respondent.

8. Complainant also advocated for a probation condition requiring respondent to undergo psychotherapy, but requiring her reporting psychotherapist to be a psychiatrist with experience treating bipolar disorder. The matters stated in Findings 13, 14, and 23 through 27 establish that such a condition is appropriate for respondent.

9. Complainant also advocated for probation conditions requiring respondent to have a practice monitor, and forbidding her to engage in the solo practice of medicine. The matters stated in Finding 19 establish that these conditions are appropriate for respondent.

10. The Board's standard terms and conditions of probation include a condition prohibiting supervision of advanced practice nurses or physician assistants. Complainant advocated against this condition, and the matters stated in Finding 45 establish that it would be unnecessary.

ORDER

Physician's and Surgeon's Certificate No. A81624, issued to respondent Catherine Elizabeth Moizeau, M.D., is revoked. The revocation is stayed, however, and respondent is placed on probation for five years upon the following terms and conditions.

1. Psychotherapy

Within 60 calendar days of the effective date of this decision, respondent shall submit to the Board or its designee for prior approval the name and qualifications of a California-licensed board certified psychiatrist who has at least five years of experience in the diagnosis and treatment of bipolar I disorder. Upon approval, respondent shall undergo and continue psychotherapy treatment, including any modifications to the frequency of psychotherapy, until the Board or its designee deems that no further psychotherapy is necessary.

The psychotherapist shall consider any information provided by the Board or its designee and any other information the psychotherapist deems relevant and shall furnish a written evaluation report to the Board or its designee.

Respondent shall cooperate in providing the psychotherapist any information and documents that the psychotherapist may deem pertinent.

Respondent shall have the treating psychotherapist submit quarterly status reports to the Board or its designee. The Board or its designee may require respondent to undergo psychiatric evaluations by a board certified psychiatrist appointed by the Board. If, prior to the completion of probation, respondent is found to be mentally unfit to resume the practice of medicine without restrictions, the Board shall retain continuing jurisdiction over respondent's license and the period of probation shall be extended until the Board determines that respondent is mentally fit to resume the practice of medicine without restrictions.

Respondent shall pay the cost of all psychotherapy and psychiatric evaluations.

2. Practice Monitor

Within 30 calendar days of the effective date of this decision, respondent shall submit to the Board or its designee for prior approval as a practice monitor the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering; shall be in respondent's field of practice; and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the decision and accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the decision, accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the decision and accusation, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this decision, and continuing throughout probation, respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor shall submit a quarterly written report to the Board or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of medical practice, and whether respondent is practicing medicine safely. It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within five calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, respondent may participate in a professional enhancement program approved in advance by the Board or its designee, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

3. Solo Practice Prohibition

Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) respondent is the sole physician practitioner at that location.

If respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the effective date of this decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3)

calendar days after being so notified. The respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, the respondent's practice setting changes and the respondent is no longer practicing in a setting in compliance with this decision, the respondent shall notify the Board or its designee within 5 calendar days of the practice setting change. If respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume practice until an appropriate practice setting is established.

4. Notification

Within seven (7) days of the effective date of this decision, respondent shall provide a true copy of the decision and the statement of issues in this matter to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

5. Obey All Laws

Respondent shall obey all federal, state, and local laws, and all rules governing the practice of medicine in California. Respondent shall remain in full compliance with any court ordered criminal probation, payments, and other orders.

6. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

7. General Probation Requirements

Compliance with Probation Unit: Respondent shall comply with the Board's probation unit and all terms and conditions of this decision.

Address Changes: Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Place of Practice: Respondent shall not engage in the practice of medicine in respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal: Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California: Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event respondent should leave the State of California to reside or to practice respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

8. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

9. Non-Practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another

state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probation Requirements.

10. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

11. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an accusation, or petition to revoke probation, or an interim suspension order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

12. License Surrender

Following the effective date of this decision, if respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to surrender his license.

The Board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

13. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

DATED: May 17, 2018

DocuSigned by:
Juliet E. Cox
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JULIET E. COX
Administrative Law Judge
Office of Administrative Hearings

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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO June 22, 2017
BY: [signature] ANALYST

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Catherine Elizabeth Moizeau, M.D.** **5168 Honpie Road** **Placerville, CA 95667** **Physician's and Surgeon's Certificate No. A81624,** Respondent.	Case No. 800-2016-021005 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On January 8, 2003, the Medical Board issued Physician's and Surgeon's Certificate Number A81624 to Catherine Elizabeth Moizeau, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on November 30, 2018, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Business and Professions Code authorizes the Board to take action against a licensee by revoking, suspending for a period not to exceed one year, placing the license on probation and requiring payment of costs of probation monitoring, or taking such other action taken as the Board deems proper.

5. Section 820 of the Code provides that whenever it appears that a licensee may be unable to practice his or her profession safely as a result of mental illness or physical illness affecting competency, the licensing agency may order an examination of licensee.

6. Section 822 of the Code provides that, if a licensing agency determines that a licensee's ability to practice his or her profession safely is impaired because of mental or physical illness affecting competency, the licensing agency may take action by revoking the licensee's certificate or license, suspending the licensee's right to practice, placing the licensee on probation, or taking such other action in relation to the licensee as the licensing agency in its discretion deems proper.

FACTS

7. On February 5, 2016, following an incident at the clinic where she was employed, Respondent agreed in writing, at the request of her employer, St. Helena Hospital Clearlake (SHHC), to cease practicing medicine at the clinic until a determination of her fitness to practice could be made. On March 4, 2016, SHHC reported the voluntary restriction to the Board pursuant to Business and Professions Code section 805 (805 Report). In addition, the 805 Report stated that Respondent was to obtain a fitness evaluation by the University of California, San Diego Physician Assessment and Clinical Education (PACE) Program.

8. On September 15, 2016 the Board entered an Order Compelling Psychiatric Evaluation of Licensee ordering Respondent to submit to an examination to be conducted by a physician and surgeon specializing in psychiatry to be selected by the Board or its designee to determine if Respondent were mentally ill to such an extent as to affect her ability to practice medicine.

9. On April 11, 2017, Respondent underwent a full evaluation by a Board appointed psychiatrist.

10. In a report to the Board dated April 15, 2017, the psychiatrist concluded that Respondent's ability to practice medicine safely was impaired by a mental illness but noted that she was able to practice medicine safely when not having an episode like the one that resulted in SHHC's request that Respondent cease practicing at the clinic. The psychiatrist concluded that Respondent should be seen by a psychiatrist rather than a non-physician therapist and be treated with mood stabilizers and possibly antidepressants to help ensure the safety of her patients and the public.

CAUSE FOR BOARD ACTION

(Mental Impairment)

11. Respondent Catherine Elizabeth Moizeau, M.D.'s certificate is subject to Board action pursuant to Sections 822 and 2227 of the Code, in that due to a mental illness, her ability to practice medicine safely is impaired.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A81624, issued to Catherine Elizabeth Moizeau, M.D.;

2. Revoking, suspending or denying approval of Catherine Elizabeth Moizeau, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Catherine Elizabeth Moizeau, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: June 22, 2017

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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